

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/17/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 655095	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/29/2008
NAME OF PROVIDER OR SUPPLIER N M HOLDERMAN MEMORIAL HOSPITAL D/P SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 100 CALIFORNIA DRIVE YOUNTVILLE, CA 94599	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS K03 Building: 01, Main building 1940's-Type 1-322 Structure Type: I - Concrete and Steel Fully Sprinklered: Wet Pipe System Annex I-Roosevelt-Dementia Unit 2007-Type V-111-Sprinklered Annex II-Eisenhower-ICF 1960's-Type V-111-Sprinklered Annex III-McKinley-ICF 1960's-Type II-222-Sprinklered K06 Plan Approval: 1940's K07 Survey Under: 2000 Existing Code The following reflects the findings of the California Department of Public Health during an annual recertification Life Safety Code survey. The findings are in accordance with 42 CFR 483.70 (a) and NFPA 101, Life Safety Code 2000 Edition, existing codes. Census = 620 Representing the Department of Public Health: Michael D. Gonzalez, HFE II-S David A. Dalley, HFE I K 012 SS=D NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1	K 000	Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the provider to the truth of the facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed because it is required by the provisions of Health and Safety Code, Section 1250, and Title 42, Code of Federal Regulations (CFR) 405.1907. This plan of correction constitutes our written credible allegation of compliance for the deficiencies noted. (Signature) Initials	
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1	K 012	K 012 Plan of Correction: The Facility will ensure building construction is free from penetrations.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Steven Anderson *SCC* *6/27/08*

any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K.012	<p>Continued From page 1</p> <p>This STANDARD is not met as evidenced by: On May 27, 2008, during a tour of the Annex 3 building or McKinley building, there was a four feet by four feet piece of sheetrock cut out on Ward 7 laundry room. Based on observation, the facility failed to maintain building construction free from penetrations. This would facilitate the spread of smoke and flame. These situations create the potential for personal injury and property damage.</p> <p>Findings:</p> <p>During a tour of the facilities with staff on May 27, 2008, the following penetrations in the building construction existed that creates a greater risk of smoke and fire spread up and horizontally above the ceiling:</p> <p>At 2:40 p.m. - Holderman Wing 2B, Shower & Whirlpool Room - An escutcheon was not seated flush against the ceiling.</p> <p>At 2:50 p.m. - Holderman Wing 2B, Electrical Panel 2B1 - A half-inch hole was in the closet ceiling to the left of the circuitbreaker panel.</p> <p>At 2:55 p.m. - Holderman Wing 2C, Hall - Three ceiling tiles were not replaced in the fire corridor outside of the multipurpose room.</p> <p>At 4:00 p.m. - Holderman Wing 1D, Shower Room - One escutcheon was not flush against the ceiling.</p>	K 012	<p>Continued from page 1: K012 Finding 1. The sheetrock missing in the laundry room of Annex 3, Ward 7 was immediately replaced. Finding 2. The escutcheon in the shower and whirlpool room of Holderman, Wing 2B, will be reset against the ceiling. Finding 3. The half-inch hole in the closet ceiling by the electrical panel in Holderman, Wing 2B, will be patched. Finding 4. The ceiling tiles in Holderman, Wing 2C hall, will be replaced. Finding 5. The escutcheon in Holderman, Wing 1D, will be reset against the ceiling. Finding 6. The escutcheons in the walk-in refrigerator #8, Holderman Kitchen Pantry, will be reset against the ceiling. Responsible: Chief of Plant Operations Monitor: Plant Operations staff will check sprinkler escutcheons when working in the areas and negative findings will be corrected. Plant Operations staff to check for penetrations when working in the area and replace caulk or patch as needed. Plant Operations staff to ensure that if panels are removed that they will be replaced upon leaving the area.</p>	06/25/08	

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K 012	Continued From page 2 At 4:20 p.m. - Holderman Kitchen Pantry, Walk-in Refrigerator #8 - Four escutcheons were not flush against the ceiling.	K 012	Continued from page 2:		
K 018 SS=E	<p>★ NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p><i>Staff</i> This STANDARD is not met as evidenced by: On May 27, 2008 at 4:30 p.m., the bathroom door located on ward 7 of Annex 3 building was tied open with a shoestring. The bathroom contained several wheelchair batteries and chargers in use. Based on observation, the facility failed to ensure that resident room and other doors along fire corridors can be closed in an instant. In the event of a fire, any impediment or obstruction would delay closing doors securely. These situations create the potential for smoke and fire spread</p>	K 018	<p>K 018 Plan of Correction: The Facility will ensure doors protecting corridor openings are free from impediment or obstructions.</p> <p>Finding 1. The Supervising Registered Nurse removed all obstructions and impediments to the resident room doors and other doors along the fire corridors, including 3A,3B,3C,3D,2A,2B,2C,2D,1B and Ward 7.</p> <p>The Supervising Registered Nurses conducted safety rounds on each ward and confirmed resident room doors and doors along the fire corridors in Holderman Hospital, Annex I, II, and III will close without a problem.</p> <p>During the unit based staff meetings, the Supervising Registered Nurses will provide nursing staff instruction regarding Fire Life Safety Code Standards, i.e. nothing should obstruct or impede the closure of the fire doors.</p> <p>Responsible: Supervising Registered Nurse</p> <p>Monitor: The Supervising Registered Nurses will conduct monthly Environmental Rounds to ensure doors can close without obstruction in the event of a fire. Findings and corrective actions will be documented on the QA data collection audit tool and reviewed in Long Term Care Quality Assurance Committee.</p>		6/30/08

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K 018	Continued From page 3 endangering clients and residents. Findings: During tours of the facilities with staff on May 27, 2008, the following impediments to closing doors along fire corridors existed: At 2:00 p.m. - Holderman 3D14 - Metal Bed Springs At 2:00 p.m. - Holderman 3D08 - Mattresses At 2:20 p.m. - Holderman 3B06 - Gerichair At 2:25 p.m. - Holderman 3A06 and 3A09 - Assembled Beds At 2:25 p.m. - Holderman 3A10 and 3A04 - Beds and Gerichairs At 2:30 p.m. - Holderman 2A03 - Overbed Table At 2:40 p.m. - Holderman 2B08 - Trashcan and Straw Hat At 2:50 p.m. - Holderman 2C01 - Overbed Table and Privacy Curtain At 2:55 p.m. - Holderman 2C07 - Overbed Table At 2:55 p.m. - Holderman 2C00 and 2C02 - Trashcans At 3:05 p.m. - Holderman 2D12 - Walker At 3:05 p.m. - Holderman 2D16 - Privacy Curtain and Trashcan At 3:10 p.m. - Holderman 2D Charting Room - Hooded Sweatshirt At 4:10 p.m. - Holderman 1B06 - Chair	K 018	Continued from page 3:	
K 021 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:	K 021	K 021 Plan of Correction: The Facility will ensure doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure will automatically close upon activation of emergency response system.	

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FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: Y00421 Facility ID: CA010000372 If continuation sheet Page 5 of 20

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K 025	Continued From page 5 penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4  This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain smoke barrier walls free from penetrations. These conditions would facilitate smoke spread across building fire protection zones/smoke compartments. Three of nineteen smoke barrier walls checked had penetrations. In the event of a fire, these create the potential to adversely affect the welfare of residents, visitors and staff. Findings: During tours of the facilities with staff on May 28, 2008, between 10:30 a.m. and 1:30 p.m., the following penetrations in smoke barrier walls were identified: 1. Holderman Ground Floor - Main/Central Corridor Adjacent to B-Wing - One-foot tear in sheetrock, missing/worn red fire stop, and two one-inch diameter holes 2. McKinley (Annex III/Section B) Second Floor - Ward 8 - No fire stop caulking around a one-inch diameter electrical conduit 3. McKinley Second Floor - Ward 9 - No fire stop caulking around a one-inch diameter electrical conduit K 027 NFPA 101 LIFE SAFETY CODE STANDARD SS=E	K 025	Continued from page 5: K 025 Finding 2. The caulking will be replaced around the one-inch diameter conduit in McKinley, Annex III, second floor, Ward 8. Finding 3. The caulking will be replaced around the one-inch diameter electrical conduit in McKinley, Annex III, second floor, Ward 9. Responsible: Chief of Plant Operations Monitor: Area will be inspected quarterly through the Health and Safety Rounds and the Fire Drill process. Negative Findings will be reported to Plant Operations for repair.	6/29/08	

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K 027	<p>Continued From page 6</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain cross-corridor doors creating the potential of horizontal smoke spread.</p> <p>Findings:</p> <p>1. During a facility tour with staff on May 27, 2008, at 4:00 p.m., the set of double cross-corridor doors would not completely close on the first floor that leads into Holderman Ward D.</p> <p>2. During a facility tour with staff on May 27, 2008, at 2:30 p.m., the cross-corridor doors would not completely close on the second floor of the central/main hall between Holderman Ward B and Ward C.</p> <p>2. During a facility tour with staff on May 27, 2008, at 2:25 p.m., one of the cross-corridor doors would not completely close on the third floor of the main fire hall adjacent to the Holderman A-Wing.</p>	K 027	<p>Continued from page 6:</p> <p>K 027 Plan of Correction: The Facility will ensure cross-corridor doors are maintained to prevent the spread of smoke.</p> <p>Finding 1. The Locksmith will adjust the double cross-corridor doors on Holderman's first floor, Wing D, to be self closing and latching.</p> <p>Finding 2. The Locksmith will adjust the cross-corridor doors on Holderman's second floor, between Wings B and C, to be self closing and latching.</p> <p>Finding 3. The Locksmith will adjust the cross-corridor doors on Holderman's third floor, Wing A to be self closing and latching.</p> <p>Finding 4. The beds blocking the cross-corridor doors in Holderman, Ward 3B, were removed.</p> <p>Responsible: Chief of Plant Operations and Nursing</p> <p>Monitor: Doors will be inspected quarterly through the Fire Drill process. Negative Findings will be reported to Plant Operations for repair.</p>	6/29/08	

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N M HOLDERMAN MEMORIAL HOSPITAL D/P SNF

STREET ADDRESS, CITY, STATE, ZIP CODE

100 CALIFORNIA DRIVE
YOUNTVILLE, CA 94599

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K 027	Continued From page 7 3. During a facility tour with staff on May 27, 2008, at 2:20 p.m., the closure of the cross-corridor doors was blocked by beds in the Holderman 3B-Wing.	K 027	Continued from page 7:	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029	K 029 Plan of Correction: The Facility will ensure that self-closing hardware is installed on storage room doors. Finding 1. Door closers will be installed on the doors to rooms 2418, 2413, 2415 in Annex II, Wards 4 and 5. (Items were removed in 2518 and no closure will be installed.) Responsible: Chief of Plant Operations Monitor: Closing mechanisms will be monitored through the quarterly Fire Drill Process. Negative Findings pertaining to the closures will be forwarded to Plant Operations by the Health and Safety Officer.	6/29/08
	This STANDARD is not met as evidenced by: Based on observation, the facility failed to install self closing hardware on several rooms converted from bathrooms and resident rooms, to storage rooms. This can increase the potential for fire where large combustible storage rooms over 50 square foot do not have self closing doors. Findings: During a tour of the Eisenhower building wards 4 and 5, on May 27, 2008 at 4:10 p.m., rooms 2418, 2413, 2415, 2518, located along the main emergency exit corridor had all been converted into storage rooms. These rooms contained cardboard boxes, mattresses, and other furniture and combustibles. The doors did not contain self closing devices which is required for storage			

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K 029	Continued From page 8 rooms.	K 029	Continued from page 8:		
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: On May 27, 2008, at 3:00 p.m., Annex 1 ward 3 dining room exit door was blocked by table stored there after use. Based on observation, the facility failed to maintain clearance in front of all interior exit doors. Obstructions in front of exits create the potential for occupants injury in the event that an evacuation is necessary during a fire or other emergency. Finding: During a tour of the facility with staff on May 27, 2008, at 1:50 p.m., two geri-chairs were partially blocking the exit door at the end of the Holderman Third Floor D-Wing.	K 038	K 038 Plan of Correction: The Facility will ensure exit doors and exit access remains free of obstructions. Finding 1. The table blocking the dining room exit door in Annex I, Ward 3, was immediately removed. Finding 2. The two Geri-chairs blocking the exit door at the end of Holderman's, third floor, Wing D were removed. Responsible: Chief of Hospital General Services Monitor: Supervisors will conduct monthly Environmental Rounds. Negative findings will be corrected immediately. Findings and corrective actions will be documented and reported through the Support Services Quality Improvement Committee.	6/29/08	
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by:	K 047	K 047 Plan of Correction: The Facility will ensure exit and directional signs are maintained with continuous illumination. Finding 1. All exit lights have been checked, replaced, or reported for repair on Wards 3B and 3C.		

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K 047	<p>Continued From page 9</p> <p>Based upon observation, the facility failed to maintain all lighted exit door and egress directional signs that would make it difficult for occupants to quickly and safely leave the building in the event that an evacuation is necessary. Confusion about where the closest exits are located create the potential for personal injury and loss of life.</p> <p>Findings:</p> <p>1. At 2:10 p.m., on May 27, 2008, during a tour of the Holderman facility with staff, three unlit exit signs existed in the main fire corridor located between Wing 3B and Wing 3C.</p> <p>2. At 9:30 a.m., on May 28, 2008, one exit door sign light closest to Medical Records in Holderman flashed on and off.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</p> <p>This STANDARD is not met as evidenced by: Based on staff interviews, the facility failed to ensure that all employees and volunteers are included in the study, review, orientation, drills, and capability to react in an emergency following published protocols, policies, and procedures. Failure on the part of any responsible staff member to respond to a fire or other emergency promptly would place occupants at risk.</p> <p>Findings:</p>	K 047	<p>Continued from page 9:</p> <p>K 047</p> <p>Finding 2. All exit lights have been checked, replaced, or reported for repair in Holderman, Medical Record area.</p> <p>Responsible: Chief of Hospital General Services</p> <p>Monitor: Sanitation has made a monthly chart for Supervisors to ensure all lights have been checked regularly. Supervisors will assign Janitors to each area and chart lights changed/or work orders submitted.</p>	06/13/08
K 048 SS=E	<p>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</p> <p>This STANDARD is not met as evidenced by: Based on staff interviews, the facility failed to ensure that all employees and volunteers are included in the study, review, orientation, drills, and capability to react in an emergency following published protocols, policies, and procedures. Failure on the part of any responsible staff member to respond to a fire or other emergency promptly would place occupants at risk.</p> <p>Findings:</p>	K 048	<p>K 048 Plan of Correction: A written emergency plan for the protection of all patients in the event of an evacuation will be maintained.</p> <p>Finding 1: Staff and Volunteers will be provided training on policies, procedures and protocols regarding how to react in case of an emergency.</p> <p>Responsible: Nursing Education, Health and Safety and Security</p> <p>Monitor: Employee knowledge will be tested during random interviews and the quarterly fire drill. Additional training will be provided to those staff with deficient answers.</p>	6/30/08


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K 048	Continued From page 10 Twenty-one employee interviews were conducted on May 28 and 29, 2008. Five staff members gave inappropriate responses when queried by the surveyor.	K 048	Continued from page 10:		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that all employees are familiar with fire response protocols and fire protection devices in their area of responsibility. Also, the facility failed to complete one fire drill per shift per quarter as required. Ill-prepared staff create the potential for not acting prudently, safely, and quickly in the event of a fire or other emergency placing themselves and residents at risk. Findings: 1. On May 28, 2008, at approximately 3:00 p.m., staff members 9 and 10 were observed during testing of the fire alarm system. Staff 9 and 10 could not locate fire alarm pull station box until after sixty seconds had lapsed after they were asked how they would alert others in the building	K 050	K 050 Plan of Correction: The Facility will ensure staff are familiar with the fire response protocols and devices in their areas. Fire Drills will be conducted quarterly per shift. <i>HHS / SA / Security</i> Finding 1. Staff will be provided training on policies, procedures and protocols regarding how to react in case of an emergency and how to locate fire protection devices in their area. Finding 2. Staff will be provided training on policies, procedures and protocols regarding how to react in case of an emergency and how to locate fire protection devices in their area. Finding 3. Fire Drills will be conducted quarterly. Health and Safety and Security will develop an easy check grid to keep track of scheduled drills. Responsible: Nursing Education, Health and Safety Officer and Security Monitor: Employee knowledge will be tested randomly and during the quarterly fire drill. Additional training will be provided to those staff with deficient answers.		6/30/08

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K 050	Continued From page 11 of a fire and summon fire emergency response crews. 2. On May 28, 2008, at 1:50 and 2:05 p.m., during an interview with staff members 1, 2, and 4, they indicated that they would "yell" or make noise to let others know in the area of a fire before pulling a fire alarm box or saying "Code Red." 3. Available fire drill documentation for the last twelve months was reviewed on May 28, 2008, and it was noted that there was no evidence of the following: a) No AM fire drills during the Third Quarter 2007 b) No NOC fire drills during the Third and Fourth Quarters of 2007 within the Holderman Building c) No NOC fire drill in McKinley Annex III during the Third Quarter 2007 d) No AM fire drill in McKinley Annex III during the Fourth Quarter 2007	K 050	Continued from page 11:		
K 054 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3  This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to maintain all smoke detectors creating the potential for smoke and fire spread. <u>Bi-ennial quantitative smoke detector sensitivity</u>	K 054	K 054 Plan of Correction: The facility will ensure smoke detectors are maintained inspected and tested per manufacturer's specifications. Finding 1. Bi-ennial Smoke Detector Sensitivity tests were conducted in the Eisenhower Building on June 29, 2007 by the Fire Alarm Contractor. The next scheduled test will be June of 2009. Responsible: Chief of Plant Operations		

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K 054	Continued From page 12 tests must be conducted within one year of installation and every other year thereafter. Early detection of smoke is important for the protection of residents, visitors and staff. Findings: EISENHOWER Documentation was reviewed on May 28, 2008, and there was no evidence of smoke detector sensitivity tests being performed by a qualified and licensed contractor since June 29, 2005, in the Eisenhower Annex (II). Bi-ennial testing is necessary unless consecutive tests yield no issues; then testing may be done every five years. Smoke detectors must have a smoke sensitivity test done every two years. After a second successful test, the test may be extended to five years. Staff Member 11 was interviewed on May 28, 2008, and documentation of smoke detector sensitivity tests for Annex II during the last 24 months were unable to be provided for review. NFPA 101 LIFE SAFETY CODE STANDARD	K 054	Continued from page 12: K 054 Monitor: Sensitivity Testing to be performed as required by NPFA 72, 10.4.2 Testing methods by our Fire Alarm Contractor.		6/30/08
K 060 SS=F	Initiation of the required fire alarm systems is by manual means in accordance with 9.6.2 and by means of any required sprinkler system water flow alarms, detection devices, or detection systems. 19.3.4.2, 9.6.2.1 This STANDARD is not met as evidenced by: Based on observation during a test of the automatic fire sprinkler system in the Roosevelt Annex (I), the facility failed to ensure that audible and visual occupant alarms and notification of the	K 060	K 060 Plan of Correction: The facility will continue to assure that the waterflow test of the inspector test valve will initiate an alarm within 90 seconds. Finding 1. Waterflow tested by electricians on May 29, 2008. Waterflow switch was adjusted to be in compliance with the code and activated within 35 seconds.		

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K 060	Continued From page 13 central monitoring station are transmitted in a timely manner. A waterflow test of the inspector's test valve (ITV) must initiate an alarm within 90 seconds. This situation creates the potential for greater property damage and risk to the health of occupants. Findings: ROOSEVELT During a tests of the Annex I ITV on May 28, 2008, at 2:45 and 2:50 p.m., the water flow did not initiate sounding of the building fire alarms within 90 seconds. The second test yielded an alarm at 2 minutes 20 seconds after the ITV was opened.	K 060	Continued from page 13: K 060 Responsible: Chief of Plant Operations Monitor: Fire alarm and waterflows will be tested quarterly by the Fire Alarm Contractor.	6/29/08	
K 061 SS=C	NFPA-101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: Based on observation, staff interview and documentation review, the facility failed to fully maintain the automatic fire sprinkler system and ensure that tamper valves on the fire water pump are secure. Proper signage, documented regular preventive maintenance, and security of tamper alarms are important elements of the fire protection system. Non-operation of the fire pump would jeopardize the adequacy of water throughout the Holderman Building's sprinkler system leaving the safety of all occupants at risk.	K 061	K 061 Plan of Correction: The facility will ensure proper signage and preventative maintenance of the fire pump. Finding 1. Signage will be installed on the Mechanical Room Door Frame and on the Fire Pump Room Door inside the Mechanical Room. Finding 2. Plumbers to churn fire pump once a week and record it in the log book. Responsible: Chief of Plant Operations Monitor: Chief of Plant Operations will monitor the log book quarterly to ensure the tests are conducted.	6/29/08	

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K 061	Continued From page 14 Findings: Prior to water flow drain tests on May 29, 2008, it was observed that there was no "fire pump inside" sign on the hallway door leading into the pump room. Staff interviews were conducted on May 29, 2008, regarding the operation of the Holderman Building fire pump. It is less than one-year old and has two tamper alarm control valves. Documents pertaining to the automatic fire sprinkler system were reviewed on May 28 and 29, 2008, and no records regarding fire pump testing were seen by the fire-life safety code surveying team. NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review, the facility failed to ensure that all building automatic fire sprinkler systems receive a full inspection, necessary repairs, and five-year re-certification or initial certification. Sprinkler systems that are not maintained in full compliance create the potential of not operating properly on-demand. This situation would lead to personal injury, loss of life, and property damage.	K 061	Continued from page 14:		
K 062 SS=C		K 062	K 062 Plan of Correction: Facility will ensure that building automatic fire sprinkler systems receive a full inspection and certification as required. Finding 1. In the Roosevelt Building on 8/15/05 Accurate Fire Protection issued a certification and warranty on the fire sprinkler system. This is in effect until 8/10. The facility wide 5 year sprinkler testing is due in 2009 and Roosevelt will be included in that testing schedule. Responsible: Chief of Plant Operations Monitor: 5 year testing to be done in 2009 for entire facility.	6/30/08	

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K 062	Continued From page 15 Finding: ROOSEVELT Available sprinkler system records records were reviewed on May 28, 2008, and it was noted that Roosevelt Annex (I) did not have an approved sprinkler risor certification documentation. A quarterly automatic fire sprinkler system inspection and testing were performed in February 2008 but a risor certification had not been obtained.	K 062	Continued from page 15:		
K 066 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4	K 066	K066 Plan of Correction: The facility will ensure smoking areas are maintained in a safe manner and that smoking regulations are adopted. Finding 1. Annex II Eisenhower patios and dock areas were cleaned by the janitors. Sanitation staff were reminded that the patio was part of their regular duties. Supervisors will check areas during their monthly rounds. Signs were posted. Smoking Policy will be reviewed With residents at the next resident Council Meeting. During Unit based staff meetings the Supervising registered Nurses will provide nursing staff and in service on the Veterans Home smoking policy. Responsible: Hospital General Services And Supervising Nurses Monitor: Supervisors will complete monthly inspections regarding the cleanliness of the patios. Negative Findings will be corrected Immediately.		6/29/08

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K 072	<p>Continued From page 17</p> <p>use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>This STANDARD is not met as evidenced by: ROOSEVELT On May 27, 2008, at 2:00 p.m., and May 28, at 2:30 p.m., a tour of Annex 1 or the Roosevelt building was conducted with facility staff. Large plastic street barricades measuring three feet high by four feet wide were arranged side by side in both wards three and zero up against the double sided emergency egress doors. In an interview with the plant operations staff, he said the barricades were needed to prevent resident movement into the un-occupied wards from wards one and two where dementia residents resided.</p> <p>MCKINLEY On a tour of the McKinley building on May 27, 2008 at 4:30 p.m., ward 7 contained four wooden chairs along the emergency exit corridor near the nurse's station. There was also 3 electric scooters stored along the corridor in front of resident rooms.</p> <p>Based on observation and interview, the facility failed to maintain halls, means of egress, and fire corridors free from obstructions. These situations would impede the safe evacuation of residents and staff. Obstructions would also hamper the aid by emergency response teams. This creates the potential for personal injury, property damage,</p>			K 072	<p>Continued from page: 17</p> <p>K 072 Finding 1. Plant Operations removed the plastic barricades in Annex 1. The Supervising Registered Nurse and/or SNII replaced the barricades with removable Velcro " Stop" signed to prevent residents from wandering into unauthorized areas.</p> <p>Findings 2 and 3. The Supervising Registered Nurse promptly removed equipment, furnishings and electric scooter along the emergency exit corridors on Ward 7, Ward 2 C and the third Floor.</p> <p>During unit based staff meetings, the Supervising Registered Nurses will provide nursing staff an in-service on Fire Life Safety Code requirements specific to maintaining halls, means of egress and fire corridors free from obstructions. Responsible: Supervising Registered Nurse Monitor: The Supervising Registered Nurses will conduct monthly Environmental Rounds to ensure all halls, means of egress and fire corridors are free from obstruction. Findings and corrective actions will be documented on the QA data collection audit tool and be reviewed in Long Term Care Quality Assurance Committee.</p>		7/15/08

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K 072	Continued From page 18 and loss of life. Findings: HOLDERMAN During a tour with staff on May 27, 2008, at 2:00 p.m., and May 29, at 10:00 a.m., beds, gerichairs and other furniture were being stored in the fire corridors of closed living areas on the third floor of Holderman. 3. During a tour with staff on May 27, 2008, at 2:50 p.m., six wheelchairs and two personnel mechanical lifts were stored in the fire corridor in Holderman Wing 2C. NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to maintain smoke dampers that are designed and have been installed to close within HVAC ducts when smoke is detected. These conditions would allow the spread of smoke from one building fire protection zone/smoke compartment to another. These create the potential for personal injury and greater property damage. Findings: 1. During record review, on May 28, 2008, of the current professional damper inspection report dated in April 2008 was reviewed. One hundred	K 072	Continued from page 18:		
K 104 SS=D		K 104	K 104 Plan of Correction: The facility will ensure smoke dampers are maintained. Finding 1. Smoke Dampers will be tested, inspected and repaired as needed by Maintenance Staff. Finding 2. Maintenance and repairs will be provided for the 51 smoke dampers located in the HVAC ductwork. Responsible: Chief of Plant Operations Monitor: Smoke Dampers will be checked during the annual inspections by the Fire Alarm Contactor.	7/15/08	

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K 104	Continued From page 19 and seven smoke dampers were tested and inspected and 51 did not successfully pass the set of tests required at a minimum of every four years. 2. Staff Member 11 was interviewed on May 28, 2008, who verified that 51 smoke dampers located in HVAC ductwork are in need of maintenance.	K 104			